



PATIENT'S INFORMATION

Date: _____ Social Security#: _____

Patient Name: _____
Last Name Suffix First Name MI

Permanent Mailing Address: _____
Street City/State Zip Code

Physical Address: _____
(If different than mailing) Street City/State Zip Code

Home Phone: _____ Cell Phone: _____

Sex: [] M [] F DOB: _____

Gender Identity: [] Female-to Male/ Transgender Male [] Male-to-Female/ Transgender Female [] Non-Binary/ Genderqueer [] Others

Employer Name: _____ Employer Phone: _____

Employer Address: _____
Street/Mailing City/State Zip Code

[] Full-Time [] Part-Time [] Retired [] Not Employed [] Self-Employed [] Active Military Duty

E-mail Address: _____

Primary Care Physician: _____

PCP City: _____ PCP Phone: _____

Marital Status: _____

Race: _____ Ethnicity: [] Hispanic [] Not Hispanic

REFERRAL INFORMATION

How were you referred to us?

- [] Physician [] ER / Urgent Care [] Family Member/Friend [] Employer [] Website [] TV [] Newspaper [] Radio

If physician or medical facility referral, please list the name: _____

Physician/Facility City: _____ Physician/Facility Phone: _____

INSURANCE INFORMATION

Primary Insurance Co.: _____

Subscriber's Full Name: _____

Subscriber's Address: _____
(If different than patient) Street City/State Zip Code

Subscriber's Sex: M F Subscriber's DOB: _____ Subscriber's SS#: _____

Subscriber's Relationship to the patient: _____

Subscriber's Employer: _____ Employer's Phone: _____

Subscriber's Employer Address: _____

Secondary Insurance Co.: _____

Subscriber's Full Name: _____

Subscriber's Address: _____
(If different than patient) Street City/State Zip Code

Subscriber's Sex: M F Subscriber's DOB: _____ Subscriber's SS#: _____

Subscriber's Relationship to the Patient: _____

Subscriber's Employer: _____ Employer's Phone: _____

Subscriber's Employer Address: _____

PARENT INFORMATION

(If minor child)

Father's Name: _____
Last Name Suffix First Name MI

Father's Home Phone: _____ Father's Cell Phone: _____

Father's Mailing Address: _____
(If not listed as subscriber) Street City/State Zip Code

Father's DOB: _____ Father's SS#: _____

Father's E-mail: _____

Father's Employer: _____
(If not listed as subscriber)
Employer's Address: _____

Mother's Name: _____
Last Name First Name MI

Mother's Home Phone: _____ Mother's Cell Phone: _____

Mother's Mailing Address: _____
(If not listed as subscriber) Street City/State Zip Code

Mother's DOB: _____ Mother's SS#: _____

Mother's E-mail: _____

Mother's Employer: _____
(If not listed as subscriber)
Employer's Address: _____

UNITY HEALTHCARE, LLC
HIPAA RELEASE OF INFORMATION

Name: _____ DOB _____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

If you want to allow us to communicate with any person, please complete the following. You may change your mind at a later date.

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:	Phone:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature: _____ Date ____ / ____ / ____

Rev 12/17

Rev 7/20

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initials

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision. I have been informed of the information in writing by my physician's office in advance of the date of my procedure.

Initials

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initials

FINANCIAL AGREEMENT: I understand and agree to all of the following:

- a. All accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor.
- b. No conditional payments accepted and payments with attempted conditions will be applied to any amounts owed.
- c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's provider, and I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
- d. I am responsible to make sure insurance payments are processed and paid promptly to my physician, and for my prompt payment of any amounts owed to Unity that are deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating provider or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services, or Unity is a non-participating provider or "out-of-network".
- e. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or \$300.00, whichever is greater.
- f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement and I agree to waive my right to a trial by jury.
- g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts and the terms of this agreement shall remain binding.

Initials

TELEPHONE CONTACTS: I authorize Unity and its affiliates and agents to contact me at the phone numbers I have provided (whether such is a cell phone or a land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me. If a machine or voice mail is reached, I understand a message may be left for me. (If you are receiving treatment from multiple Unity providers, it may result in multiple calls.)

Initials

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

Initials

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

Initials

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender identity.

Initials

OTHER PROVIDERS: I understand in addition to the attending physician, other physicians, such as radiologists and pathologists, and other providers such as laboratories and other medical professionals, may be involved in my care, and may separately bill me for their services.

Initials

PHOTO CONSENT: I consent to have my photographs taken by the provider or designated associate if required, and permit use of photographs for medical records, education, and lectures.

Initials

CANCELLATIONS OR MISSED APPOINTMENTS: A fee may be charged for any appointments not cancelled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance.

Initials

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf.

Initials

Patient Name/Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date:** _____

REV 5/20/19

Have you had in the past or do you currently have any of the following?

Patient Name: _____ Date of Birth: _____

	Yes	No		Yes	No
<u>Eyes</u>			<u>Genitourinary</u>		
Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Lasik	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Contact lens	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone/Past	<input type="checkbox"/>	<input type="checkbox"/>
RK	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<u>Psychiatric</u>		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>			
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrine</u>		
			Increased thirst	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ear, Nose, Throat</u>			Increased hunger	<input type="checkbox"/>	<input type="checkbox"/>
Hard of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Increased urination	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Increased sweating	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Fingernail changes	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>			
			<u>Blood/Lymph Nodes</u>		
<u>Cardiovascular</u>			Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Heavy aspirin use	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>			
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<u>Musculoskeletal</u>		
Difficulty lying flat	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
<u>Constitutional</u>					
Fatigue/Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<u>Skin</u>		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rash/Sores	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Lesions	<input type="checkbox"/>	<input type="checkbox"/>
			Hives/Eczema	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory</u>			Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>			
Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<u>Neurologic</u>		
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
			Numbness	<input type="checkbox"/>	<input type="checkbox"/>
<u>Gastrointestinal</u>			Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>			
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>			
Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			
Name of person or physician who referred					
<u>Immunologic</u>					
Hives	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>			
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>			
HIV	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Primary Care Physician: _____

Cardiologist: _____

Optometrist: _____

Preferred pharmacy and location: _____

Name of person or physician who referred: _____

Please list **ALL** drug allergies: _____

Please list **ALL** medications and reason you are taking them, including supplements.

Medication	Reason	Medication	Reason

Please list ALL surgeries especially heart surgeries: _____

Family History

Grandparents

	Yes	No	Self	Father	Mother	Brother	Sister	Maternal	Paternal
Arthritis									
Blindness									
Cancer									
Cataract									
Diabetes									
Glaucoma									
Heart									
High Blood Pressure									
Kidney									
Lazy Eye									
Macular Degen									
Retinal Disease									

Do you Smoke? Yes No How many cigarettes per day? _____
 Do you drink alcohol? Yes No How many drinks per day? _____
 Do you live at home? Yes No Other: _____
 Do you drive during the day? Yes No With difficulty? Yes No
 Do you drive at night? Yes No With difficulty? Yes No
 Do you use a computer or tablet? Yes No
 Do you still work? Yes No Occupation: _____

Patient or representative Signature: _____ Date: _____